GESTIONNAIRES D'ASSURANCES | SUM | STRATEGIC UNDERWRITING MANAGERS INC

A subsidiary of ONE80 INTERMEDIAIRES

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T: 416-603-7864 or 1-877-603-7864 | F: 416-603-7861 | www.suminsurance.ca

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APPLICATION – **MEDICAL MALPRACTICE INSURANCE**

VETERINARY MEDICAL MALPRACTICE

Full Name of the Applicant: _____

Trading Name (if different from above): _____

Has the applicant ever engaged in a similar activity under a different name?

☐ Yes ☐ No If Yes, please provide details: _____

Address: _____

_____

Phone: _____ Fax: _____ Email: _____

Website: _____

Practice / Trading address/es: _____
(if different from above) _____

_____

Phone: _____ Fax: _____ Email: _____

If cover is required for more than one location, please attach a list of all addresses.

1. A) AT WHICH SCHOOL DID THE APPLICANT QUALIFY?

   _____

   B) IN WHAT YEAR? _____

   C) DEGREE OBTAINED? _____

   Please give details of any additional or post graduate qualifications:

   _____

   _____

2. PLEASE GIVE FULL DETAILS OF WHAT ANIMAL RECORDS ARE KEPT, WHERE & HOW THEY ARE STORED AND FOR HOW LONG THEY ARE RETAINED:

   _____

   _____

3. A) PLEASE GIVE AN APPROXIMATE PERCENTAGE BREAKDOWN OF THE APPLICANT'S WORK BETWEEN THE FOLLOWING:

   Bloodstock: _____%

   Livestock: _____%

   Domestic Pets: _____%

   Other: _____% (please specify): _____

   B) PLEASE ESTIMATE HIGHEST-VALUE ANIMAL TREATED DURING THE LAST TWELVE MONTHS:

   _____

   C) PLEASE ESTIMATE HIGHEST-VALUE HERD TREATED DURING THE LAST TWELVE MONTHS:

   _____

   D) DOES THE APPLICANT BOARD ANIMALS? ☐Yes ☐No If Yes, please give full details:

   _____

   _____

   E) DOES THE APPLICANT'S ESTABLISHMENT HAVE AN OPERATING THEATRE?

   ☐Yes ☐No If Yes, how many: _____

4. WHAT IS THE APPLICANT'S TOTAL GROSS ANNUAL INCOME EXCLUDING INCOME FROM THE SALE OF GOODS? $_____

4. DOES THE APPLICANT OWN (WHOLLY OR IN PART), OPERATE OR ADMINISTER ANY HOSPITAL, NURSING HOME OR ANY OTHER MEDICAL ESTABLISHMENT? ☐ Yes ☐ No

   If the answer is Yes, an additional application form will have to be completed before quotations can be given.

5. PLEASE STATE THE NUMBER OF EMPLOYEES AND GIVE DETAILS OF THE CAPACITY IN WHICH THEY PRACTICE:

   _____

   _____

   _____

6. HAS THE APPLICANT, OR ANY EMPLOYEE INVOLVED IN THE TREATMENT OR CARE OF ANIMALS, BEEN THE SUBJECT OF OR CONVICTED OF ANY CRIMINAL OFFENCE, PROFESSIONAL DISCIPLINARY PROCEEDINGS OR INQUIRIES?

   ☐ Yes ☐ No If Yes, please give full details:

   _____

   _____

   _____

7. IS THE APPLICANT A MEMBER OF ANY PROFESSIONAL ORGANIZATION, OR REGISTERED WITH ANY SELF REGULATING BODY?

   ☐ Yes ☐ No If Yes, please state which and period of membership / registration:

   _____

   _____

   Has membership of / registration with such organization / body ever been suspended, withdrawn, amended or declined or had conditions attached? ☐ Yes ☐ No

8. IF THE APPLICANT IS AN EMPLOYEE, IS IT A CONDITION OF THEIR EMPLOYMENT THAT THEY MAINTAIN MEDICAL PROFESSIONAL LIABILITY INSURANCE?

   ☐ Yes ☐ No If Yes, please provide full details:

   _____

   _____

9. HAS THE APPLICANT PREVIOUSLY INSURED FOR MEDICAL PROFESSIONAL LIABILITY?

☐ Yes ☐ No If Yes, please provide:

Name of insurer: _____

Date the Policy expires: _____ Limit of Liability: _____

Deductible: _____ Retroactive Date: _____

Basis of cover (claims made or occurrence based):_____

If No, please provide details:

_____

_____

10. A) HAVE ANY CLAIMS EVER BEEN MADE TO THE KNOWLEDGE OF THE APPLICANT AGAINST THE APPLICANT, ANY BUSINESS PREDECESSORS, ANY OF THE PRESENT OR FORMER PARTNERS OR OFFICERS? ☐ Yes ☐ No

B) IS THE APPLICANT AWARE OF ANY ACT, ERROR, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM AGAINST THE APPLICANT OR ANY PREDECESSOR IN BUSINESS, OR ANY PRESENT OR FORMER PARTNER OR OFFICER? ☐ Yes ☐ No

If the answer to either 10 a) or 10 b) is Yes, complete the enclosed CLAIMS HISTORY FORM.

Note: THE POLICY DOES NOT COVER ANY CLAIM OR CIRCUMSTANCE STATED IN 10 A) AND/OR 10 B) OR ANY ERROR, ACT, OMISSION OR CIRCUMSTANCE WHICH COULD GIVE RISE TO A CLAIM, OF WHICH THE APPLICANT HAS KNOWLEDGE PRIOR TO THE INCEPTION OF THE POLICY.

11. HAS ANY PARTNER, EXECUTIVE OFFICER, DIRECTOR OR PROFESSIONAL EMPLOYEE HAD THEIR LICENSE SUSPENDED, BEEN FINED OR REPRIMANDED DURING THE PAST FIVE YEARS?

☐ Yes ☐ No If Yes, please provide details:

_____

12. TO THE APPLICANT'S KNOWLEDGE, HAS ANY COMPANY DECLINED OR TERMINATED THE INSURANCE, FOR THE APPLICANT, ANY PRESENT PARTNER OR OFFICER OR FOR ANY PREDECESSOR IN THE BUSINESS, PAST PARTNERS OR OFFICERS?

☐ Yes ☐ No If Yes, please provide details:

_____

13. WHEN IS THE APPLICANT'S FISCAL YEAR END? _____

14. INSURANCE REQUIRED:

LIMITS:	DEDUCTIBLE
☐ $250,000/$500,000	☐ $2,500(Min.)
☐ $500,000/$1,000,000	☐ $5,000
☐ $1,000,000/$1,000,000	☐ $10,000
☐ $1,000,000/$2,000,000	☐ $25,000
☐ $2,000,000/$2,000,000	☐ $50,000
☐ $3,000,000/$3,000,000	☐ Other _____
☐ $4,000,000/$4,000,000	
☐ $5,000,000/$5,000,000	
☐ Other _____	

We hereby declare that the above statements and particulars are true and that we have not suppressed or misstated any material facts and we agree that this declaration shall be the basis of any binder or contract of insurance with the Insurance Company, and that the limits and deductibles as stated in the said binder or contract of insurance shall govern.

It is understood and agreed that the completion of this declaration does not bind the Insurance Company to the issue of the insurance nor the Applicant to the purchase of this insurance.

It is further understood and agreed that if, following submission of this application to the insurer and prior to the date requested for coverage to be effective, the Applicant becomes aware of any information which has a bearing on question 10 a) or 10 b) of this application, the Insurer shall be immediately notified in writing of such information.

Signature of Applicant: _____ Dated: _____

Print Name and Title: _____

BROKER NAME: _____

ADDRESS: _____

_____

_____

PHONE NO: _____

FAX NO: _____

EMAIL ADDRESS: _____

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CLAIMS HISTORY FORM

Applicant Name: ______________________________ Date: ____________________

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$

Claimant Name: ______________________________

Project Name & Location: ______________________________

____

Date of Loss: ______________________________

Description of Claim:

____

____

____

SUIT ☐ Yes ☐ No	☐ Open ☐ Closed
AMOUNT CLAIMED	$
LOSS RESERVES	$
EXPENSE RESERVES	$
LOSS PAID	$
EXPENSES PAID	$